New Jersey Department of Health and Senior Services
INDIVIDUAL SERVICE AGREEMENT

1. Service #1 ☐Start: _____ *Effective Date* ☐Revise: _____ *Effective Date* ☐Stop: _____ *Effective Date*

2. Service #2 ☐Start: _____ *Effective Date* ☐Revise: _____ *Effective Date* ☐Stop: _____ *Effective Date*

3. Participant: _____ 4. ID Number: _____

5. Address: _____ 6. Telephone No.: _____

_____ 7. Birth Date: _____

8. Program: ☐JACC ☐CAP 9. Case Manager No.: _____ 10. Case Mgt. Site No. _____

The following services have been authorized for the above client according to the schedule and cost shown.

	Service #1		Service #2	
11. Service name				
12. Code				
	Initial	Revise	Initial	Revise
13. Unit of Service				
14. Units per Visit				
15. Frequency of Service				
16. Total Units per Week				
17. Authorized Cost per Unit				
18. Authorized Cost per Week				
19. Authorized Cost per Month (weekly cost X 4.33)				
20.	Specifications:		Specifications:	
21.	☐ Stop Services - Reason:		☐ Stop Services - Reason:	
22.	☐ Resume Services - Date:		☐ Resume Services - Date:	
23.	☐ Other - Specify:		☐ Other - Specify:	

Provider:
- DHSS will pay only for those services authorized and provided pursuant to program rules.
- The Billing Agent will be responsible for the collection of the participant's co-pay obligation.
- This notice confirms arrangements for services made by the Case Manager. You must submit an invoice at the conclusion of service or end of each month of service.
- If there is a change in the client's condition, contact the case manager immediately.
- Contact the Case Manager if you note errors in the above information or if you have any questions.

24. Provider Name	25. Provider EIN No.
26. Provider Signature and Title (Optional for Traditional & Non-Traditional providers)	Date
27. Case Manager's Name and Title	Date

WPA-8 (JCN-421)
OCT 02

Flow: 1. Authorizing Case Manager completes, signs, and sends to Service Provider.
2. Care Coordinator forwards to SIBA.